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THE
Hampden Hippocrat
SEPTEMBER—OCTOBER 1992

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The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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From the Editors

The lead article of this issue reports on an initiative taken by Dr. Mark Mullan to address difficulties that physicians are having in their dealings with the MassPro. We are also featuring a follow-up report on HDMS's Task Force on the Health Care Access Crisis. Finally, we have an interview with Dr. Nancy Weiss, who founded the Doctor for a Day program in Massachusetts here in the Hampden District in 1989. This issue appears shortly before the national election. Our next will return to our focus on more "clinical" issues and will involve articles relating to the treatment of cardiac diseases in the Pioneer Valley. ■

Brigid Glackin, M.D.
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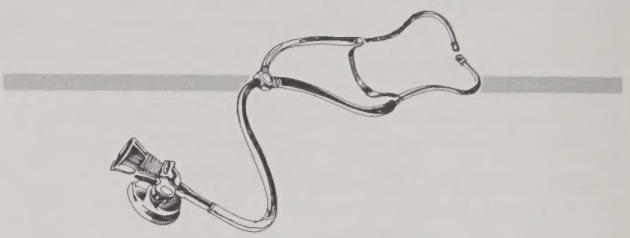

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Bruce Dziura, M.D. John P. Sullivan, M.D.

Whatever Happened to Common Courtesy

Published with permission American College of Physician Executives, College Digest.

An ad appears in a professional journal, instructing you to call if you are interested. When you call, a secretary answers and says, "Dr. X is on the phone, but if you give me your name and number, I'll have him call you." You remain in your office, waiting for the return call, but it never comes. Several days, later, you call again. The secretary says, "Dr. X has your name and number and plans to call you within the next half hour. You must realize that the doctor is very busy and hasn't been able to call you any sooner." Again you sit by the phone, and again the call never comes.

A colleague calls and says, "You've got to help me. I need a favor, and you are the only person who can help. Please take care of it and call me as soon as it's done. Call me day or night. I'll be waiting for your call." You knock yourself out helping your colleague, dropping everything else, because he or she sounds so desperate. Then you call the colleague, and what happens? You guessed it. It's a replay of the first situation.

You go to a colleague for information and advice. He or she says, "I'm glad you came to me, because I can help you. Send me your materials. I'll evaluate them and get back to you immediately." You collect the information and mail it. Then you wait a week, two weeks, three weeks... You don't hear a thing, so you write another letter, asking him if the packet arrived. Again, there's no answer. Several weeks later, you phone him. His secretary answers, "I'm sorry, but Dr. X is on vacation and won't be back for two weeks." You wait two weeks and two days, to give him a chance to catch up, and call again. This time, the secretary says, "Just a moment." Returning to the phone after several minutes, the secretary says, "I'm sorry. Dr. X. just stepped out of the office. Please give me your phone number, and I'll have him call you right back." Then the first scenario repeats itself.

You are in the middle of an important staff meeting when your secretary interrupts. "It's Dr. X. He says that he must talk to you immediately." You answer the phone and say, "Joe, it's great to hear from you. What's up?" His secretary answers, "Please hold for Dr. X. He's talking to someone else right now."

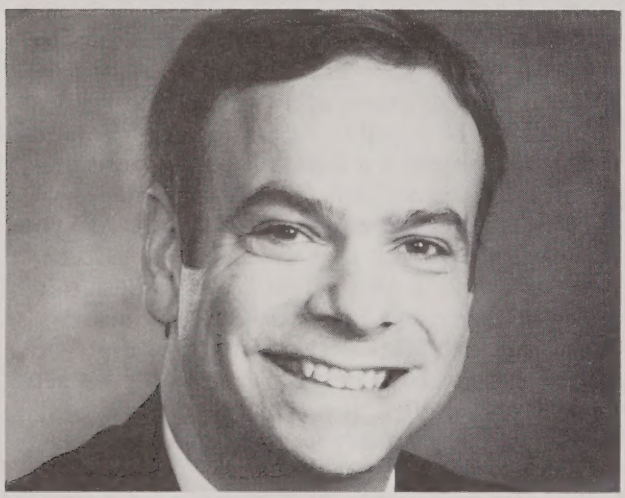
You receive a phone call from the CEO of a nearby hospital, but it turns out to be his secretary, who says, "Please hold for Dr. X. He wants to talk to you, but he's on another line right now." You wait five minutes, and the CEO comes on. "Doctor, we're going to open up a new satellite soon, and we need a dynamic, organized, progressive, far-sighted individual to run it. I can't think of a better person for the position than you. I'll tell you up front that the salary is no problem, because we want you." You discuss the offer and agree to send your C.V., because it's a "necessary formality." He assures you that you are the only person being considered. You send the C.V. and then wait... Finally, you call him back, and his secretary answers. Is it necessary to relate what happens next?

I'm sure that this lack of courtesy must upset others as much as it does me. I've thought of ways to get the other person to reply, but these methods tend to be as offensive as the behavior I'm trying to combat. Why should we have to use ruses? All it takes is a little respect and courtesy. I think I am just as busy as anyone else, and I find time to return phone calls and answer letters promptly, regardless of how distasteful the tasks may be. It may be because I treat others as I would like them to treat me, or perhaps it is because I don't want to be known as an insensitive clod. Whatever the reason, each of us owes it to our colleagues to return phone calls and answer letters. ■

Victor M. Bove, D.O.

Solutions Begin Here

As this publication reaches our readers, the country will be well into the National Election Campaign, and voting within a few weeks. The Presidential campaign will garner the most attention, and views on Health Care Reform among others, will be aired. On Capitol Hill and on Beacon Hill, the AMA and MMS have been active formulating and disseminating recommendations on specific remedies that ought to be made. Elements of our proposals



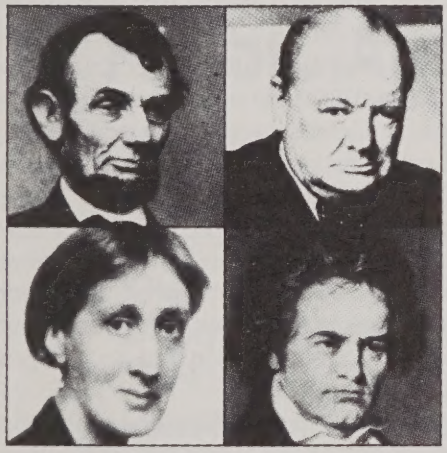
Robert V. Chircop, M.D., President

are so far included in the plans of the National candidates; we hope for more success and continued input. The process is ongoing, and only continuous, arduous representation by our Societies can be fruitful.

At the same time however, the Congress and the State Legislature are instrumental in setting policy. Locally we elect representatives to each, and we of HDMS are responsible to inform OUR Legislators on Health Care issues. We have much room for improvement here, as my own recent experience illustrates.

A few weeks ago I attended, in the audience, a seminar on Women's Health sponsored by candidate for re-election, Congressman Richard Neal. The invited speakers included the President of a local hospital, Directors of several local healthcare agencies related to women's health, Springfield Public Health Commissioner Deloris Williams R.N., Ph.D., Northampton Mayor Mary Ford, and the Congresswoman Barbara Kennelly of Connecticut. The speakers described multiple very pressing problems in women's health, including domestic violence, cancer detection, prenatal care, infant mortality, AIDS, and yes, even gender bias in medical research. I was awestruck by the magnitude and pervasiveness of these problems, and I was hardpressed to imagine all the solutions.

As I sat through address after address, I grew disturbed that neither HDMS nor any physician, was among the speakers. This is not disappointment with the Congressman, who may even have invited a physician and been declined. This is also not personal, because as many can confirm, I have no penchant for a microphone. I was disturbed because this would have been a great opportunity to address several important local public officials, two Congressmen, and additional community leaders. We could have performed a great public service. If Medicine is not invited to participate in such activities, greater visibility in the community should rectify that. If someone declined an invitation, perhaps today's readers will remember this column in the future, and refer any similar invitations to HDMS if they cannot themselves accept. Finding solutions to National problems begins at HOME. ■



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MassPRO-The Hampden Resolution

In June, 1992, Dr. Mark Mullan, then President of the Hampden District Medical Society, submitted the following resolution to the Executive Council of the Massachusetts Medical Society regarding the MassPRO. Submitting a resolution to the Executive Council is the usual preliminary step taken prior to a resolution being considered by the full nearly 500 members of the Council of the MMS which meets three times a year.

MassPRO Resolution

Whereas, The Massachusetts Medical Society is the current owner of MassPRO; and

Whereas, MassPRO often makes decisions and judgments which are felt to be inappropriate by the practicing physician; and

Whereas, The Massachusetts Medical Society should be a strong advocate for its members' rights and beliefs; and

Whereas, a conflict of interest could appear to arise between the Massachusetts Medical Society's roles as owner of MassPRO and as physician advocate.

Therefore be it resolved that:

1. All MassPRO hearings be recorded on high quality audio equipment.
2. The Massachusetts Medical Society establish an Oversight Committee to review MassPRO proceedings. This committee should be composed of Executive Committee members and report directly to it.
3. The Massachusetts Medical Society fund a payment pool to reimburse expert witnesses who testify on behalf of members who are brought before MassPRO.
4. The Massachusetts Medical Society takes steps to improve the educational process currently forced on members by the MassPRO, eliminating excessively patronizing and punitive remedial work.

When the MassPRO knew that this resolution would be debated at the Executive Council (where each district is represented by one councillor and by the district president), Dr. Brenda Richardson, president of MassPRO, sent a very lengthy letter to new MMS president Dr. William Callahan "strongly recommending" that the Hampden resolution not be passed.

Dr. Richardson argued that there was not "a high degree of participating physician disagreement" with the MassPRO. She based this opinion on the fact that when the MassPRO issued admission or partial denial notices in 1990-1991, the physician or beneficiary requested reconsideration in only 21.3% of the cases. MassPRO reversed its decision in *only* 20.9% of these reconsidered cases.

She also argued that in 1990, 88.2% of the 10,039 physicians appearing in the MassPRO date base did not have a single *confirmed* quality of care problem. She also stated that the current quality intervention plan was set up as a prerequisite to the awarding of the Medicare review contract to MassPRO and now cannot be changed without prior Government approval. Based on these and other facts, Dr. Richardson argued that MassPRO's record did not support the Hampden District's statement. She stated her belief that the MassPRO is "much more fair and much more effective, than utilization review programs operated by insurance carriers and other organizations which lack MassPRO's close relationship to the practicing physician community."

Dr. Richardson then addressed the specific recommendations of the Hampden Resolution and her remarks are quoted in full.

Quoting Dr. Richardson on:

"III. SPECIFIC RECOMMENDATIONS

A. Recording MassPRO Hearings

While every effort is made to keep these meetings at the level of internal exchange of views, MassPRO's full QA Committee. Should he/she wish to hear the proceedings, these are

available to the involved physician. MassPRO currently records all meetings at which formal Medicare sanctions may be considered."

"Meetings of MassPRO's Quality Assurance Committee are not normally recorded. Recording MassPRO QA committee meetings would serve little purpose, since this information would be confidential under the Medicare law and regulations, except in limited circumstances for disclosure to licensing, fraud and abuse and similar agencies, and to the individual physician who is the subject of review. The confidentiality of medical peer review information is important to protect the physician being reviewed and others participating in the review process from potential tort liability. Because recorded records of meetings would be disclosable to licensing and fraud and abuse agencies, we believe that most physicians reviewed by MassPRO would object to the recording of committee meetings. It should be noted that written minutes are kept, in which physician and provider anonimity is preserved."

"B. Medical Society Oversight Committee

MassPRO, not the Medical Society, is the legal entity responsible for performing the Medicare review contract. For reasons of legal liability, the Medical Society does not itself directly intervene in MassPRO affairs. Also, the Medicare contract assumes that MassPRO has full discretion to make individual review decisions independent of Medical Society pressure or influence. If the Medical Society attempted to influence individual decisions, the contract may be subject to termination. The Medical Society's role at MassPRO is to keep informed of MassPRO's general performance through participation by the Medical Society's President and Executive Vice President on the MassPRO Board of Directors.

MassPRO, after reviewing concerns previously expressed by the Hampden District Medical Society and some physicians from other parts of the state, recently appointed a 15-member Physician Relations Committee on which 12 positions are filled. This committee has broad geographical representation from throughout the Commonwealth. This committee will review substantive concerns with respect to MassPRO's performance which are brought to the committee by practicing physicians. A similar committee of hospital representatives has been functioning successfully since MassPRO was founded over

Continued on next page

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MassPRO - The Hampden Resolution

Continued from previous page

five years ago. The Physician Relations Committee should serve the legitimate purposes of the Oversight Committee described in the Hampden Resolution.''

"C. Payment Pool To Reimburse Expert Witnesses To Testify on Behalf of Physicians Subject to MassPRO Review

For the reasons given in response to III B., Medical Society funding of such a pool would not be appropriate. Further, MassPRO's record over the years does not support the need for such a pool.''

"D. Medical Society Intervention To Improve the Educational Process Currently Forced on Members by MassPRO, Eliminating Excessively Patronizing and Punitive Remedial Work.

The MassPRO quality review program has generally been accepted by practicing physicians. Physicians are not forced *to participate in MassPRO educational activities. A physician may refuse to participate in voluntary corrective actions if he/she chooses. In such instances, the formal Medicare sanction process would be invoked, and the physician would have the right to a full administrative and judicial review.''*

''As part of the MassPRO quality review program, the files related to individual educational interventions are confidential information under the PRO program. The Medical Society may not have access to this information unless the physician being reviewed provides this information to the Society. Not all physicians would be willing to have the Medical Society review this information. Therefore, the Medical Society is not the appropriate organization to intervene even if the Hampden Resolution's characterization of the educational process had merit. For the reasons given in response to 2 A. and 2 B., the Medical Society should not intervene directly to influence the quality review process.''

Dr. Mullan's resolution on behalf of the Hampden District was introduced at the Executive Council of the MMS meeting held in Waltham June 14, 1992. Dr. Richardson's letter had been distributed to council members. Rather than take any direct action on the Resolution either endorsing or rejecting it, the Council decided to form a committee composed of Council members to study the current relationship between the MassPRO and the MMS and Dr. Greg Slachta, Executive Councilor from Hampden, was named chair. This committee's report is currently pending. ■

Brigid Glackin

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Mrs. Elizabeth Canning, R.N., Director of Nursing for the Springfield Health Department, wrote to the MIAA for a definite ruling because Springfield School sports are regulated by MIAA, Inc. Their response was that the completed examination form must be signed by *the physician* and *only the physician*.

Also regarding Immunizations. Those students entering Grade 7 and 8 are required by MGL Chapter 76, Section 15 to have a second dose of measles containing vaccine.

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Health Care Access Task Force: Follow-up Report

After the Task Force meeting in June, 1992, Carol Nystrom, Executive Secretary of the Hampden District, and Michael Barnes began to meet monthly with a cohort of community leaders assembled by Kimothy Jones who is the project director for the Fetal and Infant Mortality Review Program that is ongoing in Springfield and is funded by the American College of Obstetrics and Gynecology. This group of grass roots and political leaders is still working on the process of organizing the disparate groups that already have had interest or worked on this difficult problem. It has been decided that when Springfield is ready to begin its formal campaign to address the issue, the Hampden District Medical Society will give technical and public relations assistance to the effort.

The political leaders have agreed that an aggressive community education regarding access to care program is needed.

Michael Barnes, public relations representative for the Hampden District, prepared a proposal for Dr. Murray Wapnick, Task Force Chair, which outlined what initiatives HDMS might take. The political leaders have agreed that an aggressive community education campaign regarding access is needed with all existing care givers highlighted and the educational access "cracks" which now exist would be "filled in."

Once the political process is complete, a target date to launch all efforts is going to be chosen. A "hot line" approach may be used with recorded messages of all the help which is available listed. Other proposals by Ms. Barnes include:

1. preparation of pamphlets for distribution in all hospitals, emergency rooms, physician's offices, pharmacies, some federal and state offices, ethnic group centers and the electric, telephone, cable or gas bills with a mission to educate those in need and to provide access information.
2. starting a speakers' bureau of physicians and health care providers to speak to those targeted to be in need.
3. scheduling a "house call" program to launch the effort. This is a most effective tool to reach the largest single number of people at one time and disseminate much valuable information.
4. the use of public service announcements for billboards, buses, radio, local TV, and various publications-some of these will be run as a public service at no cost.

While the work of Kimothy Jones' Program continued Dr. Tisha Dowe, who was appointed the first director of the Division of Community Obstetrics at Baystate Medical Center by Dr. Lawrence Lundy in the spring of 1992, left that position in August, 1992, and returned to her native Oklahoma.

Meanwhile, effective July 1, 1992, Mayor Robert T. Markel of Springfield named Deloris Williams, formerly deputy commissioner for the Boston Department of Health and Hospitals, as the city's new health commissioner. The position had been filled on an acting basis since 1990. Dr. Williams in an interview with the Springfield Union News, said that the development of a comprehensive health care plan for the city and combating infant mortality will be among her priorties. She plans to hold a summit on infant immortality. Dr. Williams will be the invited guest of the HDMS' next Health Care Access Task Force meeting on October 22, 1992.

Dr. Murray Wapnick offered the following remarks about the progress the Task Force has made so far:

"There's a strong relationship between sexual

transmitted diseases (STDs) and the infant mortality rate. What I'm really interested in is that we have this incredible crisis, and I don't like to say AIDS because once you say AIDS you bring up all kinds of problems—you get into gays and lifestyles and drugs. If you just lump the whole thing in STDs and say that AIDS is one of the STDs, and then you say, "What are we doing about these STDs? How are we combatting this incredible crisis?" We're doing less than we were ten years ago when the crisis wasn't as bad. I think that's why this STD thing is so unbelievable. I'd like to know exactly how we're dealing with it. I know educationally we're doing very badly. We haven't gotten the message through to the kids. And I'd like to know what's being done when someone contracts an STD—especially from the lower class. Where do they go? How good is the treatment? How good is the followup?"

"The Task Force started out just as an informational sort of study group to find out what the problems were and we thought it was important to get a broad spectrum of people involved. If you just talked to physicians you really wouldn't get down to the basic problems so we brought in a lot of people—other health professionals and nurses, administrators and other people who work close to the grassroots—and got their perspective. We looked upon these people as health workers who deserved to be heard. We got a different perspective, learned about the difficulties of getting to the clinics, the racism, the insensitivities in certain situations. A lot of those things wouldn't come from the physicians themselves because they're not there when the patient registers and they don't talk to the patients that closely as to what their problems are in getting to the clinics, so it was of some use broadening the number of people involved. So we got more people involved than we thought. The other interesting thing was that people were happy to come—they really had something to say. Some of them were quite vocal and were happy to come and tell the story of the cutbacks and effects of the cutbacks on their patients. People like Dr. Lundy came to try and show what they have tried to do and what they have accomplished in counteracting some of the problems, and he made a good presentation, but he felt he had to come to present what was being done for the rising infant mortality rate which couldn't be denied—the statistics were quite clear that something was wrong and the IMR was rising. The overall trend is high and its high when you compare Springfield to other cities like Boston and other areas of Massachusetts." ■

Brigid K. Glackin

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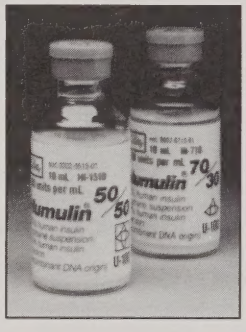

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American Medical Association

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For Your Benefit

American Medical Association Works to Redress Medicare Inequities

The American Medical Association is working to enact legislation in Congress to redress several inequities in the Medicare program.

New Physicians: Senate bill 2362 and House bill 4507 ask for repeal of provisions in the current law that mandate Medicare payment reductions for physicians in their first four years of providing care for Medicare beneficiaries.

EKGs: House bill 3373 and Senate bill 1810 would restore Medicare reimbursement for interpreting EKGs. HCFA says that it did not add sufficient money to visit codes to cover expected costs of paying for interpretation. The AMA, HCFA and medical specialty societies are discussing ways to recoup the money.

Geographic Price Cost Indices: HR 4393 and S 2680 would require HHS to use more accurate current data and consult with the state medical societies to revise the GPCIs. S 2683 requires HCFA to update GPCIs more frequently and make special adjustments for physicians in isolated areas.

Anti-Hassle: HR 2695 and S 1332 aim at reducing administrative hassles regarding secondary payors, payment errors, carrier user fees, and improving physician peer review.

Contact your senators and representatives to ask them to cosponsor these bills: 1-202-224-3121.

AMA Censures Disruptive CLIA Office Visits

The AMA, in comments on the final CLIA regulations, characterized unannounced HCFA inspections as disruptive for patients, especially those waiting for test results. The AMA recommended that inspectors:

- treat physician's offices differently from independent reference labs, and
- notify physicians ahead of time.

Materials included are excerpted from *Member Matters*, a monthly publication sent to all members of the American Medical Association.

From the MMS Regional Office

Websters Dictionary defines assist as "giving support or aid," a concept that is a component of virtually every physician's practice. ASSIST is also an acronym for "The American Stop Smoking Intervention Study," a collaborative effort of the National Cancer Institute and the American Cancer Society, along with state and local health departments and other voluntary health organizations seeking to develop comprehensive tobacco control programs in seventeen states.

Surgeon General, Antonia C. Novella, M.D., states that, "Smoking cessation represents the single most important step that smokers can take to enhance the length and quality of their lives." With this as a backdrop, the Massachusetts Department of Public Health, Office on Non-Smoking and Health, and the Massachusetts Division of the American Cancer Society have mobilized dozens of voluntary organizations, businesses, schools, hospitals, and physicians to form the *Massachusetts ASSIST Project.*

The primary objective of ASSIST is to demonstrate and evaluate ways to accelerate the decline in smoking prevalence to less than fifteen percent of adults by the year 2000. The secondary objective is to reduce, by fifty percent, the number of new smokers among adolescents by the year 2000.

For ASSIST to attain their objectives, physicians must take an active role. It is estimated that seventy percent of smokers are seen by a physician at least once a year. Of that seventy percent, only thirty-eight percent report being advised by their physicians to quit smoking or reduce the amount they smoke. Studies have shown that physicians who give smoking cessation advice, during each patient visit, significantly help their patients terminate the tobacco habit.

The National Cancer Institute has developed a smoking cessation approach based on the following principles:

- Ask about smoking at every patient visit
- Advise all patients who smoke to stop
- Assist the patient with smoking cessation
  - Help set a quit date
  - Provide self-help materials
  - Prescribe nicotine-substitution therapy if appropriate
- Arrange follow up visits for the patient

Because of the recent advances in pharmacologic interventions to address nicotine addiction, physicians have an unprecedented opportunity to assist their patients with smoking cessation. To be effective though, interventions must not only address the pharmacologic addiction, but also the psychological addictions associated with tobacco use.

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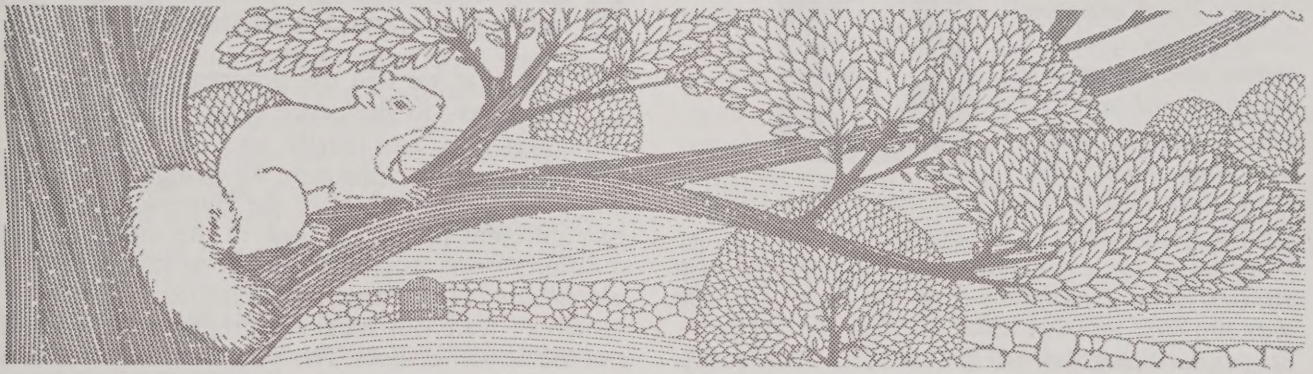
To support physicians, and their office staff, with this profound task, a training for health care providers, *"Telling Is Not Enough: How To Help Your Patients Stop Smoking,"* has been scheduled on Wednesday, November 4, 1992. Springfield Marriott, Springfield, MA. Dr. Francis Riley, chair of the Public Health Committee of Hampden District, is vice chair of Lower Pioneer Valley ASSIST.

The program is designed to help physicians develop the skills needed to successfully counsel patients on smoking cessation. The three-hour program will explore ways of intervening with patients who smoke; it will review prescribing protocols for pharmacologic aids; and it will help the physician implement simple procedures within their office practices that will ensure that patients who smoke are treated in an efficient, uniform fashion. Registration information and additional details regarding this conference may be obtained by phoning 1-800/562-0102.

Cigarette smoking is the leading cause of premature death in this country. Physicians, as health authorities, are in a unique position to intervene with their smoking patients and provide the counsel and the support necessary to combat this tragedy. For more information on how to become involved with the ASSIST project, please contact the MMS West Central Regional Office, 1-800/522-3112. ■

Kerin L. Milesky
Regional Coordinator
Massachusetts Medical Society



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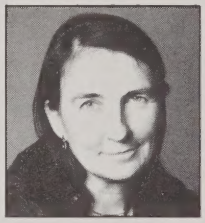
Dr. Nancy Weiss:
Founder, Doctor For A Day Program



Nancy Weiss attended Swarthmore College where she majored in zoology and pursued her interest in vocal and flute music. She then completed medical school at Temple University in Philadelphia. She began her surgical training at the University of Rochester and also studied at St. Elizabeth's Hospital in Boston. She was the first woman chief resident at the then Springfield Hospital in 1975. She is now an instructor in surgery at the Baystate Medical Center where this year 50% of the trainees will be women. She was the first woman president of the Hampden District Medical Society in 1989. During her year as president, she initiated the Doctor for a Day Program in Hampden County and has continued to chair the program which is now in its third year. She discussed the program recently with The Hippocrat.

Q Where did you find out about this program which was founded in Colorado?

A I heard about it from the New England Journal of Medicine and I was really impressed by it because it seemed like such a great idea. In the Colorado program, the doctors and the participating legislators spent three days together, and if you spend three days with someone you really get to know them fairly well. In the Colorado program, as described in the New England Journal, the physicians set up such a sympathetic feeling with the legislators that it was found if something came up later that the legislators needed clarification about they would simply call up their doctor friend. In Colorado the program was done by the Colorado state medical society and they feel that this has improved things a lot for doctors there.

Q How has the program here changed since you started it in June 1990?

A This year we had the program in three locations—in Berkshire County, in the Worcester area, and locally, so we're expanding toward a statewide approach. We changed it in other ways. We decided to have the layperson go with two different physicians, one in the morning and a different one in the afternoon so that more physicians could participate. The first year the "interns" were our local state representatives and our local state senators. This year we have expanded it to representatives of the media. In the second year we invited business people and presidents of local banks. This year we tried to think of some other people we should build bridges with and we also had the presidents of the bar associations in addition to local radio and TV representatives. I didn't take legislators myself into my own practice because I was the backup person in case some physician who was a participant had to back out. Actually we've had some legislators and other participants who were laypeople back out, but we've never had a doctor cancel. I feel really good about that and that's been three years in a row that every single physician who volunteered lived up to his or her commitment. Approximately thirty physicians participated in the program when we held it this past June.

Q What kind of ground rules do you have?

A The ground rules are that nothing is staged. Whatever happens, happens during the day, but there's nothing artificial. We do have a session in the morning as an orientation and at that session I stress confidentiality. I stress to the laypeople that they are really very privileged to be in patients' treatment lives and that they are to remember the context of what they see, but none of the details of the patients' lives.

Q How did you handle the technical aspects of the program?

A The Colorado Medical Society was very nice in sharing the technical aspects of the program, for instance, obtaining releases from patients. Karin Milesky from the Regional Office of the Mass. Medical Society coordinated our contacts with them and she did this so well. We provided the patient releases that were required. Every patient that was involved in this signed a release and we provided these releases to the hospitals as well.

Q What kind of feedback did you get from both sides?

A The legislators were surprised about all the decisions that we have to make all day long. The doctors on the other hand were surprised about some of the questions which they thought anybody would know the answer to because as physicians we don't realize what the level of knowledge is among the legislature about what we really do. The legislators were also surprised about the physical stamina that it requires to do what we do. We sort of take it for granted walking around the office, going down the stairs, going to the hospital, doing two things at once. Figuring things out like if I stop to see Mrs. Jones here will I have time to stop and do records?

Q Don't you think politicians do that or is it just not the same?

A The first year the politicians invited the doctors who were participating to join them in the State House if they wanted. The only one who did that was Dr. Tom Clark. Tom said that no, it was really a much more casual thing. The legislators did not have short, intense interactions with people the way we do. They would be doing things during the day, but any one thing might take much longer then what we do. For me, until I participated in this program, I never even thought about this aspect of our work. I really thought "Isn't that what everybody does?"

Q Do you think the politicians are talking about the intensity that exists in our relationships with our patients?

A Yes, I think legislators were talking about the intensity in the daily lives of physicians at work because that's what I feel myself.

Q So, how do you wrap up this intense day?

A At the end of the day all of the doctors and their interns come back and we have a wrap-up session. We talk about what they got out of it, what we could do differently, and what related kinds of things the medical society can do. The legislators said that they don't pay much attention except to the things that go on in their own committees. So if we want to make a point to them, we should educate them about the issues on a subject when it is coming up to a vote, but otherwise they're not paying any attention. If you really want to make an impression, they like it if you go to see your legislator personally and (very interesting to me), they're really impressed with people who come in groups. If you can get three or four people to come at the same time then they're more impressed with that than if three or four people came at different times on the same topic. In the first year of the program, there were so many doctor volunteers and you spent the whole day with one person that I was able to have a physician-constituent matched with his own legislator for the program.

Q Did the flavor of the program change when you were dealing with the media people and the business people versus the legislators in the wrap-up session at the end of the day?

A They were just different personalities. People from the legislature were used to, in many ways, selling themselves. In the wrap-up session, they would give little speeches that had mostly to do with themselves, rather than what had impressed them during the day. The head of the bar association said we should do more of these kinds of things because so often the two groups are viewed as antagonists.

Q Did you get tired of doing this? Why did you keep doing it?

A Because the first year was the work. Like so many things at first it's hard and then after that it gets a lot easier. Like we have the letter prepared explaining the program. We have the release forms. We know who to contact at the hospitals to get permission. I've kept doing it because I think it should go on, but I've said if anybody else wants to do it, take it over, change it, make it something that they want to do, feel free.

Continued on next page

Interview Dr. Nancy Weiss

Continued from previous page

Q Is there something else to do with the program now? Do you think it should be expanded statewide like the Colorado program?

A I think it would be good. I still would like to focus on the legislators in such a way that they would know some physicians pretty well. For instance, when Brian Lees was there the first year he said that this was the first time he'd ever had any interaction with a physician. And that was true for most of the others except for Jordan from Wilbraham and Catjakas from Springfield. And Iris Holland at that time who is now retired. The others had never had a physician call them up about anything so they had absolutely no interest in things that concern us. I see it as a way that physicians hopefully ultimately will become more politically active. Whether that will ever happen I don't really know. I believe physicians should act on something other than just taking care of patients.

Q As physicians, don't you think we're really more isolated than we realize?

A I'm not sure I know what you mean. I think we're highly individualistic. We don't want to work for somebody else. We want to make all these decisions we have to make and we don't think in terms of going and asking for something from someone else. I wonder if doctors aren't more active in the community, for instance on the school committee or volunteer work, because they think they're already doing enough for the community.

I would like to see this particular program continue. I would hope to get other people involved. I think this political interest among doctors even though it so far has not surfaced is vital. I feel that we can be a force for change, at least on a state level.

Q So what do you think the role of a doctor should be politically?

A Two things. I think advocacy is one thing. At the legislative breakfast this year we dealt with three things. There was legislation pending regarding AIDS, regarding the requirement to wear seat belts, and the issue of the Medical Examiner's office and we made presentations about these to the legislators at the breakfast. We sat around with these guys and got them all to come and listen to why we support these three pieces of legislation. I think it's important that we do that, but I would also hope that the legislators would get something out of this—just a better idea about medicine and what we do because I think some of the laws that get passed are so incredibly unrealistic. ■

Brigid K. Glackin

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1221 Main Street
Holyoke, MA 01040

Born: May 15, 1952
Premed: State University of New York-Stonybrook 1976-1979
Medical: The Medical College of Pennsylvania 1980-1984
Internship: Baystate Medical Center 1984-1985
Residency: Baystate Medical Center 1985-1987
Specialty: Internal Medicine

Robert Parker, D.O.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: March 25, 1954
Premed: Springfield College 1972-1976
Medical: Kirksville College of Osteopathic Medicine 1978-1982
Internship: Osteopathic Hospital of Maine 1982-1983
Residency: Baystate Medical Center 1983-1985
Fellowship: Baystate Medical Center 1985 Washington University School of Medicine 1986
Specialty: Anesthesiology

Christine A. Sickle, M.D.
2341 Boston Road
Wilbraham, MA 01095

Born: April 16, 1949
Premed: Allegheny College 1967-1971 University of Pennsylvania 1984-1985
Medical: Medical College of PA 1985-1989
Internship: Baystate Medical Center 1989-1990
Residency: Baystate Medical Center 1990-1992
Specialty: Pediatrics

Martin Lesser, D.O.
1236 Main Street
Holyoke, MA 01040

Born: October 17, 1951
Premed: City College of New York 1969-1973
Medical: New York College of Osteopathic Medicine 1984-1988
Internship: Coney Island Hospital 1988-1989
Residency: Catholic Medical Center of Brooklyn & Queens 1989-1991
Specialty: Family Practice

Brian M. Kiessling, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: March 8, 1963
Premed: University of Michigan 1981-1984
Medical: Wayne State University School of Medicine 1984-1988
Internship: Oakwood Hospital, Michigan 1988-1989
Residency: Baystate Medical Center 1989-1992
Specialty: Anesthesiology

Stuart D. Helms, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: October 17, 1962
Premed: University of Vermont 1980-1984
Medical: St. Louis University School of Medicine 1988-1992
Internship: Baystate Medical Center 1992
Specialty: Internal Medicine
Resident

Continued on next page

New Members Welcome

Continued from previous page

Paul J. Helmuth, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: August 22, 1966
Premed: Goshen College, Indiana 1984-1988
Medical: Northeastern Ohio University College of Medicine, Ohio 1988-1992
Internship: Baystate Medical Center 1992
Specialty: Internal Medicine/Pediatrics
Resident

Cary M. Dash, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: November 7, 1962
Premed: Tufts University 1980-1984
Medical: Medical College of Pennsylvania 1988-1992
Internship: Baystate Medical Center 1992
Specialty: Internal Medicine
Resident

Barry Slitzky, M.D.
299 Carew Street
Springfield, MA 01104

Born: December 13, 1959
Premed: University of Rochester 1977-1981
Medical: SUNY at Stony Brook 1982-1986
Internship: Wadsworth VA/UCLA 1986-1987
Residency: Wadsworth VA/UCLA 1987-1989
Fellowship: Yale University School of Medicine 1989-1992
Specialty: IM/Gastroenterology

Jeffrey C. Wint, M.D.
80 Congress Street
Springfield, MA 01104

Born: October 8, 1960
Premed: University of Pennsylvania 1978-1982
Medical: Columbia University 1982-1986
Internship: Robert Wood Johnson Medical School 1986-1987
Residency: Robert Wood Johnson University 1987-1991
Fellowship: Hand Center of Western New York 1991-1992
Specialty: Hand Surgery/Orthopedics

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In Memoriam

Dr. Thomas F. McCarthy, 81, of 22 Churchill St., a retired obstetrician and gynocologist, died Tuesday, July 7, 1992 at home.

He was a practicing physician for 55 years, and delivered more than 15,000 babies.

He was graduated from Boston College in 1933, and Harvard Medicial School in 1937. He trained in surgery and obstetrics-gynecology at Boston City Hospital, and was certified by the American Board of Ob-Gyn in 1948.

He served on the staffs at Baker Memorial Hospital and Faulkner Hospital in Boston, and St. Elizabeth's Hospital in Brighton. On moving to Springfield, he joined the staff at Baystate Medical Center and Mercy Hospital, and Providence Hospital in Holyoke.

He was also a consultant at Wing Memorial Hospital in Palmer, Ludlow Hospital, Noble Hospital in Westfield, and the Holyoke Soldiers' Home.

He was a Navy veteran of World War II, and served as a flight surgeon in the Atlantic and Pacific theaters. He served aboard the escort carriers, USS Ellyson and USS Cumberland Sound, and was aboard the battleship, USS Missouri, in Tokyo Bay on Sept. 2, 1945, when Japanese delegates signed an unconditional surrender.

He was a member of the American College of Surgeons, the Boston Obstetrical Society, the New England Obstetrical Society, the Western Massachusetts Obstetrical Society, and the American Medical Association.

He was also a member of the Massachusetts Medical Society, the Hampden District Medical Society, the Harvard Club of Boston, and the Harvard-Radcliffe Club of Western Massachusetts.

In November 1989, he was one of the last Americans to pass through "Checkpoint Charlie," the crossing point between the former East and West Berlin, hours before the fall of the Berlin Wall.

His wife, the former Kathleen Mellen, died in 1989. He leaves three sons, Thomas P. of Walpole, Peter R. of Springfield and Sean P. of Pembroke Pines, FL.; three daughters, Kathleen F. McCarthy of Watertown, Sara A. Brand of McLean, VA, and Martha M. McCarthy of Springfield; a sister, Mildred McCarthy of Boston, and seven grandchildren. ■

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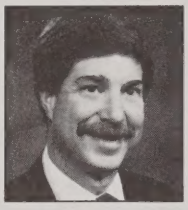
- the tax treatment of employees versus independent contractors?
- structuring employment, partnership and shareholder agreements for group practices?
- malpractice claims due to inadequate informed consent?
- reducing estate taxes, and protecting assets from creditors' claims?
- providing for the orderly disposition of your practice in the event of death or disability?



Attorney
Arthur W. Price

Arthur W. Price and Michele J. Feinstein, partners in Cohen, Rosenthal, Price, Mirkin & Wernick, have more than twenty-five years of combined experience in representing area physicians in their practices and individually. They counsel solo and group practices in their day to day businesses as well as in their planning for growth or extraordinary concerns. They also advise physicians on personal and family problems.

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The AMA and Medical Liability: Principles of Reform

The American Medical Association believes that as the national debate on health care reform proceeds, we must address its high cost, inefficiency and inequity of our medical liability system.

The Problem

People injured by medical malpractice or defective medical products are entitled to fair and prompt compensation for their injuries. All parties should have the right to fair and cost-effective dispute resolution. The AMA believes that in resolving medical and product liability claims, the civil justice system currently:

- Costs too much and works slowly;
- Fails to provide access to the legal system or fair compensation to most patients, while providing exorbitant awards to others;
- Is unable to promptly or cost-effectively identify unfounded claims;
- Fails to promote quality health care or protect patients from avoidable injuries;
- Adds billions annually to the national health care bill in medical liability premium costs and by encouraging doctors to practice "defensive medicine" to hedge against potential lawsuits;
- Threatens access to health care, especially high risk services, such as obstetrics and emergency room care;
- Unnecessarily adds to the cost of pharmaceuticals and medical devices, and
- Inhibits health care product research and development, reducing the availability of potentially valuable new drugs and medical devices.

The impact of our medical liability system has been studied extensively. These studies agree that this inefficient system adds to the serious problems of making health care services available to all and making these services cost-effective.

The federal government, as the single largest purchaser of health care services, has a strong interest in promoting available and quality medical care and managing its cost. Because of that concern, it should take the lead to address medical liability problems.

Principles of Medical Liability Reform

The over 100 groups including the AMA that participate in the **National Medical Liability Reform Coalition** support the principles articulated below. These principles should guide any restructuring of the current medical liability system.

1. **Availability of Health Care:** A compensation system for medical injury should promote the basic goal of providing access to all necessary health care service to all.
2. **Quality of Health Care:** A compensation system for medical injury should deter substandard or unethical practices and encourage improvements in the safety and quality of medical care.
3. **Patient-Professional Relationship:** A compensation system for medical injury should enhance a cooperative relationship between patient and providers, based on mutual respect and effective communication.
4. **Fair Compensation:** A compensation system for medical injury should compensate patients injured by malpractice adequately and equitably.
5. **Prompt Resolution:** A compensation system for medical injury should resolve claims promptly.
6. **Innovation:** A compensation system for medical injury should encourage innovation in diagnosis and treatment, leading to better care.
7. **Predictability:** A compensation system for medical injury should provide predictable outcomes with respect to findings of liability and amount of awards.
8. **Cost Effectiveness:** A compensation system for medical injury should operate efficiently and economically.

We urge the Congress and the President to work on meaningful medical liability reform legislation consistent with the above principles.

Materials included are excerpted from *Member Matters*, a monthly publication sent to all members of the American Medical Association.

The Last Word

Letters to the Editors

Your editors frequently receive letters from readers of the **Hippocrat**. We thought we would share some of these with you.

Dear Editors:

I was not amused by your recent attempt at humor. Your sophomoric attack on mindless beauracrats was in very poor taste. In the past, you have insulted lawyers (the Snavely T. Reptile articles), insurance companies (the Universal Insurance Form), radiologists (the reference to the CAT scan made in your "From the Editors" column of the Radiology issue) and numerous other people, things, and events none of which are funny. Humor of any kind has no place in a serious journal such as the **Hippocrat**! In fact, I am against humor in any form, anywhere, whatsoever!

Humorlessly,
A serious reader

Editors: You spelled "bureaucrat" wrong. We think.

Dear Editors:

I read your last issue with great interest. There were seven misplaced commas, twelve misspelled words, one proper name that was not spelled right, and a sentence in which there was a dangling participle.

I suggest you hire a professional editor. It is a scandal that a magazine like the **Hippocrat** would allow these errors to slip by. I am sure most of your other readers have at one time or another pointed out your sloppy editing.

Sincerely,
Disgruntled Reader

Editors: Get A Life.

Dear Editors:

I have carefully gone over the last two years of **Hippocrats** and have seen no mention of Vice President Dan Quayle. Do you realize that you are the only magazine or newpaper published in the United States which has neglected this important public figure? Even though you pretend to be above politics, it is obvious that by neglecting to mention a major Repubican politician, you are playing into the hands of the Democrats. Cancel my subscription!

Sincerely,
Republican M.D.

Editors: Next month, we devote an entire issue to Dan Quayle.

Dear Editors:

In your issue devoted to general medicine you did not include any comment on the role of nurse practitioners in general medical practice. Nor did you discuss the evolving specialty of Medicine-Pediatrics. Nor did you point out that general obstetrician/gynecologists are much better suited to care for women than are internists or family practitioners. Why did you not devote an article to the important role of general internists in Emergency Medicine? And was the fact that you left out anything about the raging competition between family practice and general internal medicine for recent medical school graduates a deliberate slight, or merely sloppy reporting? I hope you realize that I, or probably any one of your readers, could do your job much better than you!

With contempt,
Disappointed reader

Editors: Everything was deliberate. Sorry.

Dear Editors:

Please, no more *stereotypes*. It is not dangerous to shake hands with a gynecologist. Orthopedists are not all muscle bound jocks. Pediatricians are not physiologic adults with the emotional development of six year olds.

Pathologists do not dress in black and visit funeral homes on their days off. Surgeons are not knife-happy wild-eyed zanies who lop off body parts with abandon. Radiologists do not keep moles and bats for pets. Anesthesiologists do no sniff glue when they have time off. Internists are not usually pencil-necked near-sighted geeks who wear clashing colors.

People who use stereotypes are as dishonest as lawyers and as opportunistic as politicians!

Sincerely,
W. Scopeslipper, M.D.

Editors: Sorry, your letter is too inflammatory to print in the **Hippocrat**. But thanks, anyway. ■

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☐	☐	We look forward to another computer system upgrade
☐	☐	Our claims are never arbitrarily denied
☐	☐	We enjoy hearing "All our agents are busy now, please hold"
☐	☐	Insurance carriers are always consistent in handling our claims
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